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Title of Innovation: Innovations at the Deckplate: Population Health

Date Submitted: 10/28/2004

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Background: Naval Medical Center San Diego (NMCSD) has developed a groundbreaking approach to population-based healthcare. Using the “MTF Road Map to Successful Disease Management”, based on Wagner’s Chronic Care Model, we have been able to effectively and quickly use this framework to deploy diabetes, asthma, and CHF evidence-based initiatives, and improve clinical metrics at our large MTF. Clinical Quality Teams (CQT) have developed and deployed mandated evidence based on-line clinical management training (with CME) for all PCMs based on command-wide clinical practice guidelines (CPG). Diabetes and asthma registries with standardized performance reports available on the command intranet dashboard; provider profiling, and proactive patient contact lists were developed and deployed. Clinicians have CHCS web-based point of care decision support tools (e.g., alerts for required tests; co-morbidities, diabetes specific lab summaries and CPGs) available during diabetic patient encounters, as well as lists of assigned patients via the web-based “Easy CHCS” portal. This improves productivity by enabling all clinic staff to intervene to provide evidence based care at every patient interaction. Implementation and sustainment of these initiatives are strengthened by the CQTs and the command’s formal Clinic Management Team (CMT) structure.

Methods: An implementation model was designed that integrates the efforts of the clinical quality command goal teams, Population Health and Data Application Departments. Baseline data for each population was obtained from the M2, and following initial development, extensive data validation of the new clinical information tools was conducted. Descriptive statistics are calculated for the diabetes, asthma, and CHF populations at the command and clinic levels, and are trended over time using control charts. Clinics can now do the same for each of their providers at their desktop PC. Using HEDISâ and HP 2010 benchmarks, targeted Population Health metrics are also displayed on the command intranet performance dashboard. Additionally, parametric statistics (e.g., ANOVA) have been used to examine the mean HbA1c results between clinics and individual providers. Statistically different results between the mean HbA1c values have been found between some clinics and providers. This data with identifiers removed will be displayed.

Results: For > 6,000 total patients with diabetes mellitus, we improved our annual testing rates for HbA1c from 57% to > 75%, retinal exams from 24% to > 36%, and microalbumin from 32 to 45%. To further improve these rates, we are pilot testing the use of the CHCS PAS mailer system to automatically send diabetic patients “overdue notices” for required annual lab tests in two clinics. Baseline ED visits and admissions for asthmatics were better than the HP2010 targets. However, use of long-term controller medications for enrolled patients 5-56 years was 66.6% (HEDISâ 90th Percentile=74.4%). Based on the results seen in diabetes, this clinical indicator should improve with the roll out of the asthma registry and clinical alerts, coupled with the on-line training, and other education and marketing efforts. Baseline hospitalization rates for CHF patients were above the HP2010 targets. In response, we began a Group Medical Visit (GMV) utilizing the skills of cardiologists, nurses, pharmacists, dietitians, and a mental health nurse practitioner. The GMV is aimed at improving the

health status of CHF patients by facilitating coordination of care, increasing self-efficacy and self-management skills through social group support and patient education. GMV program evaluation metrics have been developed. Standardized CHF hospital-wide admission order sets have also been created by the CQT.

Conclusions: NMCSD has operationalized the 6 elements of the "MTF Road Map to Successful Disease Management": (1) Leadership exemplified by the Command Goal Teams; strong clinical champions, periodic evaluations by the governing board; (2) CPGs and Metrics that are used command-wide, available on the intranet, and use metrics based on the CPGs with national benchmarks that are given to clinicians on a regular basis; (3) Disease Management Reengineering: population-based and individual patient decision support tools, changes in clinic business processes to proactively identify and bring in patients for evaluation, defined roles and responsibilities of CMT members, group medical visits; (4) Program Deployment: Mandated online clinical management training, standing "order sets" for routine tests, self-management classes; (5) Education: all staff educated about new clinical and business processes; (6) Marketing: the Population Health Department, and the CQTs have an ongoing plan that includes house staff. In summary, this multi-faceted approach applies the multidisciplinary collaboration required for the coordinated, evidence based clinical management for diabetes, asthma, and CHF populations, as well as for individual patient encounters. Every effort is designed to enhance provider productivity, achieve the best outcomes, targeted to the needs of our patients, with an emphasis on timesaving evidence-based approaches. NMCSD's clinical management training, patient education materials, functional rules and validation methodologies for the clinical information tools, CHF admission order set, and clinic level business processes are available and can be adapted for other populations and settings. A population-based healthcare delivery system will "Keep our patients healthy and feeling good about themselves."

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